



## KEWEENAW BAY INDIAN COMMUNITY

COMMUNITY ASSISTANCE PROGRAM (C.A.P.) OFFICE

16429 Beartown Road, Baraga, MI 49908

Telephone: (906) 353-6623 x4162 Fax: (906) 353-4141

### **FY2015 CAP HOUSEHOLD APPLICATION**

You are required to update physical address with Enrollment before applying for **ANY** of the programs in the CAP office

#### **HEAD OF HOUSEHOLD INFORMATION**

LAST Name	FIRST Name	Middle	Social Security #	DOB	AGE	TRIBAL ID

#### **OTHER HOUSEHOLD MEMBERS INFORMATION**

LAST Name	FIRST Name	Relation to HOH	Social Security # Grant programs only	DOB	AGE	TRIBAL ID

Mailing Address	Physical Address	City/State/Zip	County	Telephone/cell/message

Is anyone in the home a Veteran? [ ] Yes [ ] No	Does he/she have a DD214? [ ] Yes [ ] No
Name:	
Does he/she receive benefits from the VA? [ ] Yes [ ] No If Yes, please indicate what benefits he/she is receiving:	Would he/she like more information on programs available through the VA? [ ] Yes [ ] No

#### **PLEASE CHECK EACH OF THE FOLLOWING for COMPLETED APPLICATION:**

- [ ] I certify that all of the information in this application is true, accurate, and complete to the best of my knowledge. I understand that giving false or incomplete information may result in a referral to the prosecutor for fraud, and/or recovery of any funds paid out on behalf of me, my household, or a minor in my care.
- [ ] I understand that failure to submit a completed application and all of its required documents will be considered incomplete and a determination of funding benefits will not be made on the request until all documents are received and application is filled in completely.
- [ ] A decision will be made on my application within 10 working days of my initial application request date.
- [ ] I understand that I have a right to file an appeal for denials and decisions not made in a timely manner. Hearings-Appeals procedure sheets can be obtained in the CAP office.
- [ ] I hereby authorize the Release of Information on myself or any other member in my household, in order to obtain information specific to this application and related requests.

\_\_\_\_\_  
Head of Household/Applicant Signature

\_\_\_\_\_  
Date



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### **Tribal Elder Pension (TEP)**

### **HEATING PROGRAM APPLICATION**

Must reside in Baraga County, Ontonagon County, or on Marquette Trust Property

KBIC Member 62+ years of age.

**Ontonagon County was added to Heating Program effective December 11, 2014 per Council Motion.**

### **Heating Assistance**

**December 11<sup>th</sup>, 2014 – May 31<sup>st</sup>**

**Please submit a copy of current heating bill with completed application.**

<b>Primary Heating Vender:</b>	<b>Account number:</b>
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I hereby certify that all of the information in this application are true, correct, and complete to the best of my knowledge. I understand that giving false or incomplete information can result in referral to the prosecuting attorney for fraud, and/or recovery of funds paid on my behalf.

I understand that failure to provide all necessary information and documentation can result in denial of my application. I also acknowledge that I will only submit bills for payment that are allowable under the program (Primary Residence ONLY).

My heat is included in my rent, so therefore, I am submitting a copy of the lease/landlord statement indicating his/her name and company name (if applicable) and address along with the monthly rental amount stating that the heat is included in the rent.

I hereby authorize the release of information by the appropriate agencies (e.g. income sources, heating vendors, landlords); (i.e. Ojibwa Housing Authority, Social Security Administration, Veterans Administration, Baraga and Marquette County DHS) to the Keweenaw Bay Indian Community.

I also understand that an inquiry of my last twelve (12) monthly heating billing statements may be made to the appropriate heating vendor to verify that I/My Spouse are the responsible party for the heating bill at our primary residence, year round.

I FURTHER UNDERSTAND THAT IF FRAUDULENT BILLING STATEMENTS ARE SUBMITTED, I WILL BE INELIGIBLE TO RECEIVE HEATING ASSISTANCE FOR THE BALANCE OF THE HEATING SEASON FOR THE FISCAL PERIOD.

\_\_\_\_\_  
*Applicant's Signature*

\_\_\_\_\_  
Date